REPUBLIC OF GHANA

What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

NAVRONGO HEALTH RESEARCH CENTRE

Vol. 2, No. 26, August 2002 Navrongo Health Research Centre

DISTRICT 88888 CALLING!

After the Navrongo Community Health and Family Planning Project (CHFP) proved that it was practical and beneficial to deploy Community Health Nurses to live and provide doorstep health care in rural Ghana, concerns were raised over the practicality of scaling up Navrongo nationally. Now over 30 districts throughout the country are organizing health care delivery using the Navrongo model. Even outside experimental conditions, some districts have achieved results worthy of emulation, especially by Navrongo standards. One district which has shown great promise in the implementation of CHPS is Sene in Brong Ahafo Region. Created in 1989, Sene is one of the youngest of the region's 13 districts and is the largest district in the region—covering a land area of 8,586 sq km—five times the size of Kassena-Nankana District. Located in the eastern part of the region, 3500 sq km of Sene District's total land surface is made up of islands. With Kwame Danso as its administrative capital, Sene shares common boundaries with Atebubu to the west, the Volta Lake to the north and east, the Digya National Park of the Afram Plains and the Sekyere East District of the Ashanti Region to the south.

Sene District—where inspiring figures on paper match facts on the ground

The vegetation is mainly of the savanna type, with traces of the deciduous forest in some areas. The district has two main seasons—rainy and dry. Farming is the main activity employing about 75 percent of the population and produces food crops such as tubers, legumes, cereals, and miscellaneous vegetables; yams and groundnuts are the main cash crops.

According to projected figures from the 2000 Population and Housing Census, Sene District has a population of 87,058, however, the District Health Administration, which likely has a more detailed account of the population by virtue of the depth of its activities, puts the figure at 88,888! The District Director says outreach suggests the actual population may be in the hundred thousands since new villages are discovered every year.

There are four traditional Councils in the programme area, each with a Paramount Chief and comprised of the indigenous ethnic groups Dwan, Wiase, Bassa, and Nkomi, respectively. Other ethnic settler groups, which can be found in the district, are Dagarbas, Dagombas, Kokombas, Bators, and Asangbes. There are a number of religious groups dominated by the Seventh Day Adventist and the Muslim sects.

The communication infrastructure in the district is rudimentary. Only the main road from Atebubu to Kojokrom is accessible year-round—all other roads are simply tractor tracks made by tractors leading to/from farm settlements to transport produce. There is also a 17 km feeder road from the centre of Kwame Danso to Akyeremade Bator, a community on the bank of the Sene river. However, all these roads are rendered impassable during the rainy season, making accessibility to most of the communities impossible.

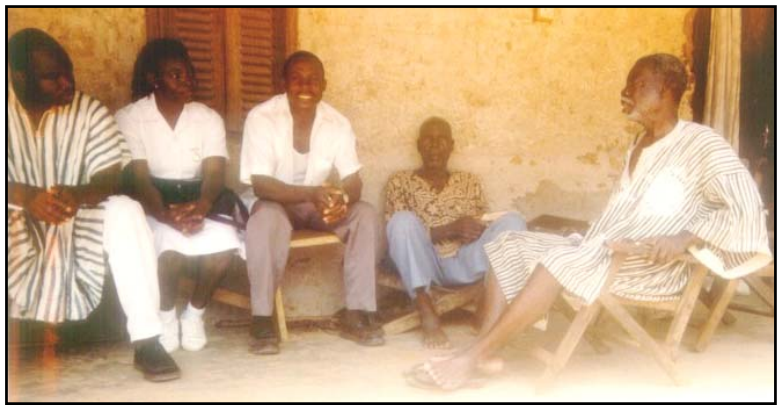
The only communication links with the outside world are the Post Office and two telephone installations in the district capital. There is a communication centre for the District Assembly and one for the Ministry of Health. The district has been divided into four subdistricts for Ministry of Health activities. These subdistricts are Kwame Danso, Bantama, Bassa, and Kojokrom. The only Government Health facilities in these four subdistricts are Kwame Danso Health Centre, and Bassa, Kajaji and Kojokrom Rural Clinics. In addition to these are two private clinics—Sunta and Nya Kkwa Clinics. There is one private midwifery facility that does not function regularly. The four Government Health

facilities have a total staff of 32, including three Field Technicians for disease control, one Technical Officer for community health, and five Community Health Nurses.

CHPS organization

The two selected zones for CHPS implementation are Bantama and Kyeamekrom. Bantama is located 8 km west of the district capital, while Kyeamekrom lies 20 km east. Bantama has 11 communities, which include Bantama Lailia, Wiase, Shafa, Dogondagyi, Maframa, Gruma Akura, Chense Bator, Adu Kofi, Nyanda, and Konkomba Akura. Kyeamekrom has a population of 8157 over a land area of 287 sq km. The zone is made up of 19 communities: Kyeamekrom, Atta Akura, Apaaso, Chaboba, Tendam, Kulungugu, Dagomba Akura, Kofi Gyan, Kwaku Donkor, Kwabena Kuma Akura, Bangyi, Sergeant Major, Agege Line, Kapacha Akura, Tato Bator, Dagarti/Kokomba Akura, Donkope and Kakraka Akura, and Ghamakpe.

The main economic activities for both zones are farming, fishing, and petty trading. Both zones are governed by subchiefs popularly called 'Odikro'. They are assisted by ethnic group leaders, Assembly members and Unit Committee members. Kyeamekrom has an Area Council.



Chief of Kyeamekrom announcing that a site for a permanent Community Health Compound has been secured for the Community Health Officer

The two areas designated for CHPS have no health facilities. The District Health Administration has detailed one Community Health Nurse to take charge of the Bantama zone. She moves into the community during immunization sessions and conducts child welfare clinics but has no accommodation within the community. Staff from the disease control and MCH units in Kwame Danso go into the various communities in the Kyeamekrom zone to conduct immunization and child welfare clinics.

Some of the major health problems identified in the two zones include Malaria, diarrhoea, hernia, Onchocerciases, convulsion, pregnancy-related problems (eg. anemia, eclampsia). Since there are no health facilities in these areas, people rely on chemical sellers, drug peddlers (quack doctors), and the use of local herbs in treating or managing these ailments. These problems contribute to high morbidity and mortality and also affect food production and eventually productivity and the standard of living. Though the disease burden is spread across all ages and both sexes, records show that woman and children bear the brunt of unsatisfactory medical care.

The idea of sending a Community Health Officer into these communities has been welcome news. The chief of one of the CHPS zones has pledged that when a nurse is sent to their community they would make her safety and comfort their priority. The community would provide the nurse with foodstuffs. The chief cited the example of how they treated a German volunteer in the past *"We would support the CHO much the same way as we supported the German volunteer and even do more"*, assured the Chief of Kyeamekrom, Nana Paul Mensah, at his humble Palace before his Assemblyman, Mathew Addae and the Youth Leader of the town, Kofi Fofie.

The people anticipate that with the relocation of the resident nurse, doorstep health delivery will improve health indicators, which, given the particularly difficult circumstances under which the District Health Management Team works, is a lot to call home about.

Send questions or comments to: What works? What fails?
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This series has been launched to share experiences with people in Ghana and elsewhere around the world about what has worked and what has failed in an experiment to make primary health care widely accessible to rural people. The Kassena-Nankana community, whose active participation made *The Navrongo Experiment* possible, are hereby duly acknowledged. This publication was made possible through support provided by the Office of Population, Bureau for Global Programs, Field Support & Research, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-99-00010. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development. Additional support was provided by a grant to the Population Council from the Bill and Melinda Gates Foundation. The Community Health Compound component of the CHFP has been supported, in part, by a grant from the Vanderbilt Family to the Population Council.